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Leonard D. Goodstein, Ph.D. **Wilfred G. van Gorp, Ph.D.**

C O N F I D E N T I A L

February 25, 2010

Via Electronic Mail

Stephen P. Heymann, Esq.
Assistant United States Attorney
Office of the United States Attorney
District of Massachusetts
1 Courthouse Way, Suite 9200
John Joseph Moakley Courthouse
Boston, MA 02210

Re: *United States v. Gonzalez*
08-CR-10223-PBS, 09-CR-10262-PBS09 and 09-CR-10382-DPW

Dear Mr. Heymann:

As you requested, this letter summarizes my psychiatric impressions of Mr. Albert Gonzalez, the principal defendant in the above-referenced matters. You will recall that I evaluated him in the Wyatt Detention Center, north of Providence, Rhode Island, for much of the day on February 1, 2010 and over the course of the morning the next day (in aggregate, about 7.5 hours). During the initial session, I administered the Minnesota Multiphasic Personality Inventory, Second Edition, Restructured Form (MMPI-2-RF).[1] Prior to administering it, I re-

[1] The MMPI-2 is the oldest comprehensive psychological test designed to assess psychopathology. It has been standardized on, literally, thousands of subjects and provides objective indications of significant psychological disorders. It is designed to measure traits, long-term, relatively stable components of personality, more than states, short-term fluctuations that vary with situational distress. The test not only measures personality, but includes indices of validity that allow the interpreter to make assessments about the subject's test-taking biases. Those assessments include whether the individual was attempting to minimize or amplify his/her symptoms, whether the individual was answering randomly or whether the individual was capable of understanding the items. The current edition of the MMPI-2 includes several new scales that not only increase the test's validity, but better probe the test's core function of categorizing, mostly serious, psychopathology. The newest version, the "Restructured Form," modified in 2008, adds new clinical scales, expands the important validity scales and adds meta-scales that distill certain socially useful clinical issues such as impulsivity or aggressiveness. In brief, the restructured form (an unexpected bonus is that the RF version is substantially shorter and can

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minded him that in order to produce a valid result, he needed to answer straightforwardly, consistently and to be open to acknowledging ordinary human flaws and foibles. He said that he understood these suggestions, would heed them; subsequently, he completed the test efficiently in about ninety minutes.

His evaluation had been requested by you and had, as I understand it, been occasioned because Mr. Gonzalez's counsel, Martin G. Weinberg, Esq., had placed into evidence the psychiatric report of Barry H. Roth, M.D. Of course, Dr. Roth's report speaks for itself; however, in essence, it concludes that Mr. Gonzalez had during the time of the pled offenses three psychiatric disorders: substance abuse, internet addiction and "many elements consistent with..."Asperger's Disorder.[2] Further, Dr. Roth opines that as a result of these conditions that Mr. Gonzalez had, at the time of the instant offenses, an impaired mental state. As argued by Mr. Weinberg, that impaired state significantly reduced Mr. Gonzalez's mental capacity at the time of the pled crimes and thus falls within the ambit of his having diminished capacity during those acts. You asked that I endeavor to assess Mr. Gonzalez's mental state overall; paying particular attention to the three disorders described by Dr. Roth, but being open to other disorders, if any, as well.

You explained that Mr. Weinberg and you had discussions about whether he would attend his client's evaluation; the upshot being that he did not, but that I would not ask any questions about the charged offenses or Mr. Gonzalez's mental state at those times. At the outset of his evaluation, I confirmed these ground rules with Mr. Gonzalez who indicated that he was aware of them, and we abided by them throughout his evaluation.

You have supplied me with various documents that I have considered in forming the opinions expressed below (each to a reasonable of degree of medical and/or psychiatric certainty): chapter 4 from the Handbook of Autism and Pervasive Developmental Disorders, Volume 1, 3rd Edition, Asperger Syndrome by Volkmar and his colleagues; the New Jersey indictment, the New York superseding indictment; the Massachusetts indictment; Dr. Roth's report of December 14, 2009; a redacted version of Mr. Weinberg's sentencing memorandum; an article by Haskins, B.G. and Silva, J.S. entitled, Asperger's Disorder and Criminal Behavior: Forensic-Psychiatric Considerations, J Am Acad Psychiatry Law 34:374-384, 2006; Judge

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be completed in an hour or two) provides a more multidimensional overview of the evaluee's psychopathology, if any.

[2] I have twice previously evaluated individuals in criminal matters where the issue of Asperger's was raised. In both of those matters, I was retained by the defense, and in both I found that the defendants suffered from that disorder.

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Saris's orders concerning defendant's psychiatric exam, dated December 21, 2009 and January 27, 2010; your motions to compel defendant's psychiatric evaluation and defense counsel's opposition to those motions; an editorial from the American Journal of Psychiatry about internet addiction (165:306-7, March, 2008); memoranda entitled NY offense conduct and MA offense conduct; and article from Isr J Psychiatry Relat Sci (Vol 43, No. 3, 2006 166-173 entitled Criminal Responsibility in Asperger's Syndrome; a memorandum entitled offense conduct; Chapter 5, Part K, Departures of the 2009 Federal Sentencing Guidelines Manual; and finally, the Interpretive Report for the MMPI-2-RF, generated by the computer program licensed by the Regents of the University of Minnesota, NCS Pearson and PsyCorp for authorized scoring of the test.

As I checked into the Detention Center, I was apprised that Mr. Gonzalez was already in an interview room and awaiting my arrival. He appeared to be a lean and very fit man (at one point, he explained that he could no longer do the 5000 pushups he once did regularly and probably could only do 600) of about six feet who shook hands firmly, made excellent eye-contact and appeared cooperative and ready to answer my questions. These initial impressions were confirmed and amplified during his evaluation: he was unfailingly cooperative, seemed forthcoming and disclosing, was obviously unusually intelligent and thoughtful, and appeared regretful both for having cooperated with the Secret Service (he explained that his prior cooperation had him considered as an informant, resulting in his needing to be in protective custody and therefore having reduced access to others prisoners, some of whom might be good company) and for continuing his criminal conduct (he indicated that had he pled to the original charges in 2003 and not cooperated, that he would, probably, be on the verge of being released).

Of all the clinical issues raised by Mr. Gonzalez's mental state assessments (irrespective of by whom), the least controversial is that, to the extent that Mr. Gonzalez can be believed, there appears to be little doubt that he has significantly abused many recreational pharmaceuticals, including alcohol, tobacco, marijuana, ketamine, LSD and others. In his discussions with me, he described being intoxicated and/or stoned many days during the periods at issues. Obviously, I was not there when Mr. Gonzalez engaged in his admitted abuse, and cannot confirm his statements, but they appear to be reasonably realistic (perhaps because they have an aspect of an-admission-against-self-interest about them). However relevant clinically, there would appear to be few forensic implications to Mr. Gonzalez's drug abuse, irrespective of how extensive or robust, because it was voluntary. Further, at this point, whatever kind of withdrawal syndrome from which he might have suffered is now resolved and thus of little enduring clinical import.

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Asperger's Disorder is a psychiatric disorder with manifold characteristics, but predominately with certain developmental delays, verbal skills exceeding performance skills and with ongoing social awkwardness (the previously mentioned article by Volkmar and his colleagues presents a lucid and thoughtful history of this disorder). Some clinicians have averred that Asperger's occurs along a spectrum (as, in fact many human attributes do) and that higher-functioning individuals have only some aspects of the syndrome. Thus, Dr. Roth apparently found that Mr. Gonzalez has many aspects of Asperger's. I say apparently, because ordinarily psychiatric diagnoses are made against a set of referenced criteria (presently, those found in the Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition, Text Revision published by the American Psychiatric Association, and copywriten in 2000). Dr. Roth does not describe the criteria he found, or why in their absence, he made the diagnosis; that does not necessarily mean that he is mistaken, but it makes his reasoning difficult to follow.[4]

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[4] (The footnoting software, Word, for some unexplained reason has skipped number 3.)

The DSM –IV-TR criteria for Asperger's are as follows:

A. Qualitative impairment in social interaction, as manifested by at least two of the following:
(1) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
(2) failure to develop peer relationships appropriate to developmental level
(3) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
(4) lack of social or emotional reciprocity

B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
(1) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
(2) apparently inflexible adherence to specific, nonfunctional routines or rituals
(3) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
(4) persistent preoccupation with parts of objects

C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

D. There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).

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During my evaluation of Mr. Gonzalez, he struck me as engaging, very bright, self-aware and quite personable. I endeavored to explore his social awareness, his ability to empathize and his ease (or lack thereof) with others, especially women. Mr. Gonzalez made a number of statements that convinced me he was, as an adult socially aware and connected. First, he described to me acquiring his first computer and his fascination with it, with programming and security. For the period from about age 12 until he moved to New York to work for Fortune City, it does appear that he was rather computer obsessed and somewhat asocial; this period was broadly speaking that of his adolescence. I say somewhat because despite his greater interest in computers than people he had sexual relations with young women at ages 12 and 14 and was able to hook up, largely at will thereafter. His facility of casually meeting and engaging women (whether for a social or sexual encounter) is antithetic to that usually ascribed to those with Asperger's and tends to invalidate that diagnosis.

More importantly, Mr. Gonzalez explained that while employed at Fortunecity he decided that he needed to make more friends if he were to have greater influence in his practice of internet security; thereafter, consciously (and comfortably) made more friends and developed the greater influence he sought. Again, this pattern is the opposite from the usual one in Asperger's were individuals overwhelmingly fail to appreciate the utility (and pleasure) of social relations. Here, Mr. Gonzalez not only appreciated the utility of social relations, he was able, seemingly rather easily, to establish them.

Mr. Gonzalez described his sometimes stormy relationship with his girlfriend, Jenny. He acknowledged that he had often treated her in a less than ideally supportive fashion, but that he really loved her and was profoundly appreciative for how she had reached out to him and his parents even after his arrest, when he was in the company of another woman. His ability to empathize with her anger at him and to feel apparent contrition for his treatment of her argues against an Asperger's diagnosis. Overall, these examples reflect the history that Mr. Gonzalez provided and make a diagnosis of Asperger's virtually impossible. As I see it, his behavior does not meet *any* of the DSM-IV-TR criteria for Asperger's.

E. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.

F. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia

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Additionally, the pled criminal conduct of Mr. Gonzalez, although not discussed with him, seems to demonstrate that he was the leader of a group of remarkably computer savvy (and sadly effective) hackers. Those with Asperger's are almost by definition, not leaders. Instead they are followers, often perceived as peripheral, isolative and strange.

As you appreciate, psychiatrists routinely endeavor to assess the quality of the rapport established with an evaluee (or patient). During his assessment, Mr. Gonzalez appeared present, focused and engaged. He did not appear odd, strange or ill-at ease (ordinarily, a certain degree of anxiety would be expected). Again then, these qualities significantly weaken the possibility of an Asperger's diagnosis. In summary then, that diagnosis does not fit with Mr. Gonzalez's clinical state, presently, nor as it appears to have been in the past.[5]

Internet addiction may describe a genuine clinical condition; however, it is not a diagnosis in the present nosology (the formal diagnostic structure as expressed in DSM-IV-TR) and it does not appear that it will be a diagnosis in the forthcoming Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (as the next edition will be known) as the anticipated changes in the forthcoming Manual were officially posted on the American Psychiatric Association's web site on February 10th and internet addiction was not included. Thus, it cannot be considered a psychiatric disorder. The integrity of the Diagnostic and Statistical Manual, which underpins the entire diagnostic process, is only maintained by having multiple experts consider the evidence for each diagnosis and to develop specific criteria for that diagnosis whenever new ones are made part of the formal diagnostic nomenclature. Without such panels agreeing upon a new diagnosis and its criteria, there can be no such diagnosis. Of course, science advances over time, and it is possible that one day such a diagnosis will be recognized. In the meantime, psychiatric editorialists such as Jerald J. Block, M.D., will fill a legitimate professional role in drawing attention to a clinical condition with potential diagnostic implications.

In Dr. Block's editorial about internet addiction, he observes that, typically, such "addiction" falls into three patterns; in effect, gaming, sexual interests and chatting/e-mailing. Insofar as I could tell, and again, I believe I was enjoined from seeking specific information about Mr. Gonzalez's computer use from him (but not from reading the Presentencing Report), Mr. Gonzalez's internet usage, no matter how intense or compulsive did not fit into any of the three likely patterns. Instead, Mr. Gonzalez explained that he loved the puzzle and challenge

[5] Because Asperger's almost always presents as part of persistent developmental delays, it is a diagnosis that is usually considered and made in childhood. Periods of unusual behavior, and I am assuming *arguendo* that Mr. Gonzalez's fondness for and recurrent activity with computers is unusual, that develop and resolves during adolescence are typically considered to be anomalies of that often-challenging transitional period.

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of internet security (he appears to have really meant "hacking") and for him, the computer was as essential tool of his trade; not too dissimilar to the way computerized word processing is necessary (or at least facilitative) for a judge, attorney or forensic expert.

Irrespective of addiction (that is irrespective of whether such "addiction" is a true DSM diagnosis and whether Mr. Gonzalez actually had it, if it were), his conduct, judging by his plea appears to have strayed far from "addiction," especially from the three kinds described by Dr. Block. Fraudulently securing millions of credit cards numbers is by no means part of ordinary "addiction," no matter who is defining such addiction; instead, it is criminal behavior, presumably, reflecting numerous illegal transactions. Overall then, Mr. Gonzalez does not have internet addiction because there is no such psychiatric entity (in the present or proposed DSM) and because even if there were, his pattern of internet usage is manifestly different than those who have that purported disorder. Finally, even if he had "internet addiction," there is nothing in that disorder that would cause him to steal.

Mr. Gonzalez's MMPI interpretative report (annexed to this letter) adds important additional information about his diagnoses. His validity scales, reported on page 2 of the report, demonstrate that he was open during the testing process and not prone either to over- or under-reporting; thus, the clinical interpretations are considered useful and valid. Four scales are of clinical significance (with a T Score of 65 or more): antisocial behavior (RC4, page 3), juvenile conduct problems (JCP, page 5), substance abuse (SUB, page 5) and disaffiliativeness (DSF, page 5). Mr. Gonzalez's antisocial scale is elevated because he acknowledged past problems with the law (and the same is true with juvenile conduct problems) and because his relationships with others have tended to be superficial and exploitative, and because he reports difficulties with authorities and impulsive behavior. His substance abuse history is again evident. Finally, it is apparent that he is disinclined to join groups or organizations. Each of elevations is relatively small with the exception of antisocial behavior. The test report indicates that a diagnosis of antisocial personality disorder (page 8) is the most likely diagnosis (diagnoses are listed in the order of probability). The MMPI does not probe issues of internet use, so the failure to find that disorder cannot be considered dispositive. However, the average-range scores on RC7 and RC8 (dysfunctional negative emotions and aberrant experiences, reported on page 3) tend to further rebut the notion of his having Asperger's disorder as negative emotions and highly-unusual experiences are sometime concomitants of that disorder. Again, however, the MMPI is not designed specifically to probe any of the developmental disorders, including Asperger's.

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Stephen P. Heymann, Esq.
Assistant United States Attorney
Re: *Mr. Albert Gonzalez*
February 25, 2010

Overall, during the course of a comprehensive psychiatric evaluation, I found considerable evidence of Mr. Gonzalez's substance abuse and probable[6] antisocial personality disorder. I found no evidence of Asperger's disorder or internet addiction, although much evidence for extensive internet usage.

If you wish additional information, please let me know.

Sincerely,

Mark J. Mills, JD, MD

[6] I say "probable" because under the terms of his assessment, I could not (and did not) make inquiry into his mental state at the time of his criminal activity, something that would, most probably, have confirmed his antisocial personality diagnosis.

MMPI-2-RF™

Minnesota Multiphasic Personality Inventory-2 Restructured Form™

Interpretive Report: Clinical Settings

MMPI-2-RF™

Minnesota Multiphasic Personality Inventory-2-Restructured Form™

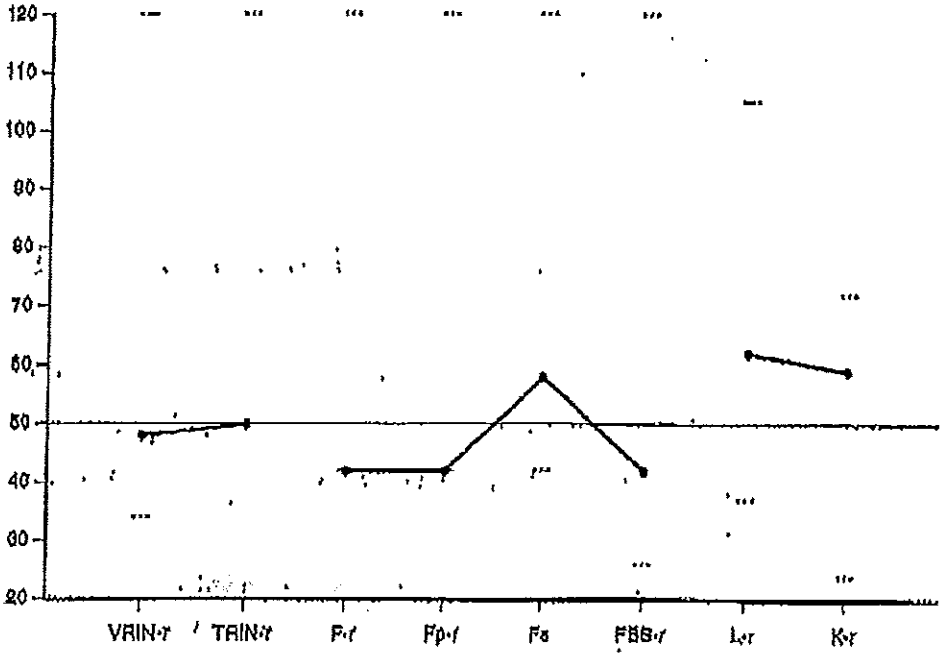
Yossef S. Ben-Porath, PhD, & Auke Tellegen, PhD

Name:	Albert ,, Gonzales
ID Number:	[redacted]
Age:	28
Gender:	Male
Marital Status:	Never Married
Years of Education:	12
Date Assessed:	02/01/2010

PEARSON

PsychCorp

MMPI-2-RF Validity Scales



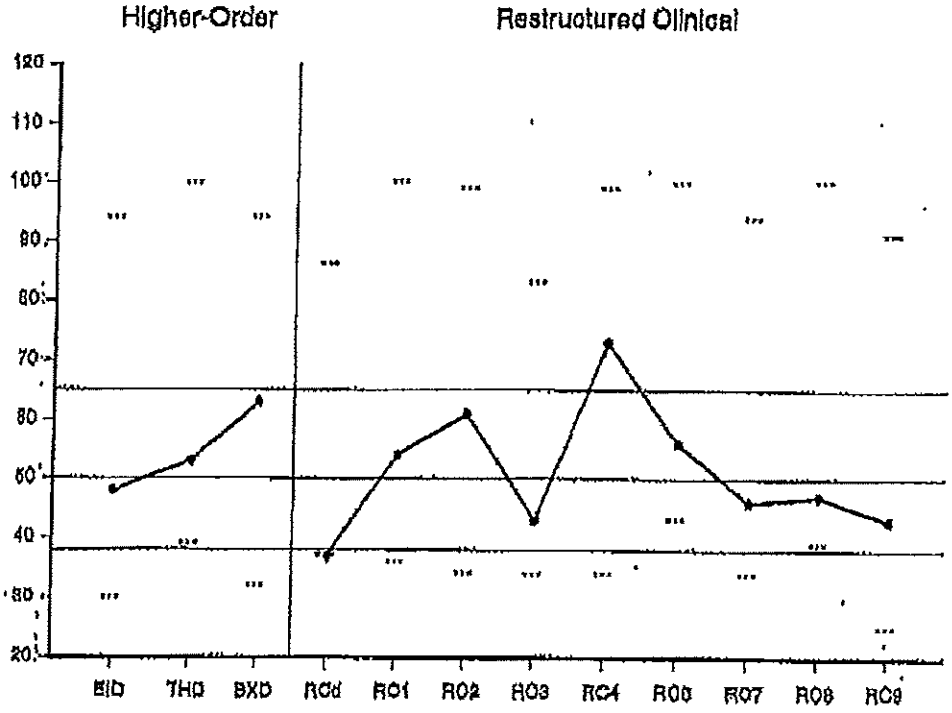
	VRIN-r	TRIN-r	F-r	Fp-r	Fs	FBS-r	L-r	K-r
Raw Score:	8	11	0	0	2	5	5	10
T Score:	48	50	42	42	58	42	62	59
Response %:	100	100	100	100	100	100	100	100

Cannot Say (Raw): 0 Percent True (of items answered): 29%

The highest and lowest T scores possible on each scale are indicated by a '—'; MMPI-2-RF T scores are non-gendered.

VRIN-r Variable Response Inconsistency
TRIN-r True Response Inconsistency
F-r Infrequent Responses
Fp-r Infrequent Psychopathology Responses
Fs Infrequent Somatic Responses
FBS-r Symptom Validity
L-r Uncommon Virtues
K-r Adjustment Validity

MMPI-2-RF Higher-Order (H-O) and Restructured Clinical (RC) Scales



	EID	THD	BXD	RCd	RC1	RC2	RC3	RC4	RC6	RC7	RC8	RC9
Raw Score:	8	2	11	0	4	7	3	18	1	4	1	8
T Score:	48	53	63	37	54	61	43	73	56	48	47	49
Response %:	100	100	100	100	100	100	100	100	100	100	100	100

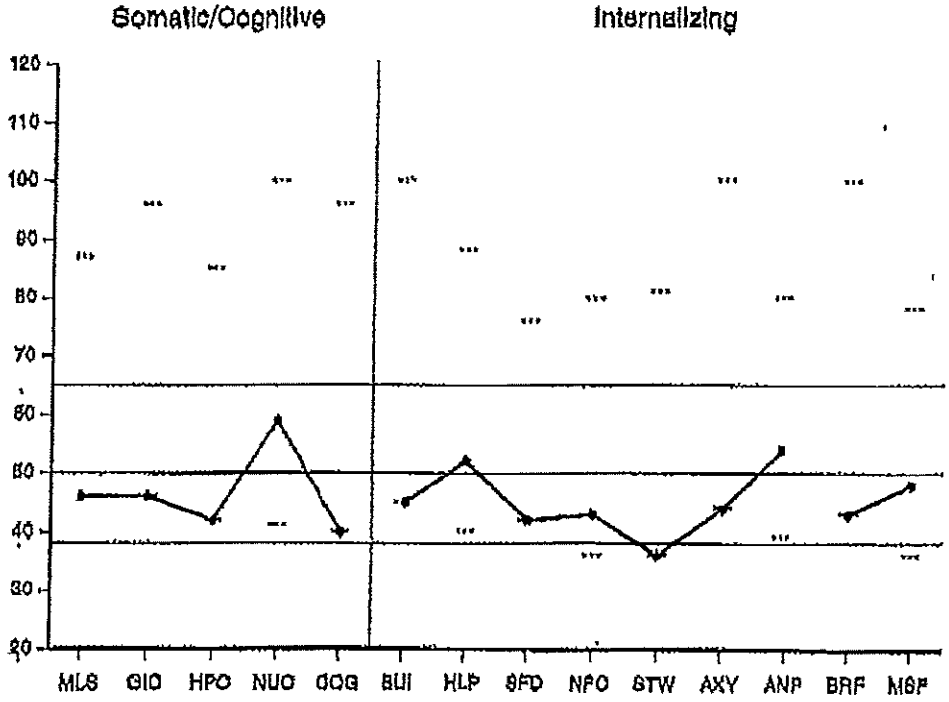
The highest and lowest T scores possible on each scale are indicated by a "---". MMPI-2-RF T scores are non-gendered.

EID Emotional/Internalizing Dysfunction
THD Thought Dysfunction
BXD Behavioral/Externalizing Dysfunction

RCd Demoralization
RC1 Somatic Complaints
RC2 Low Positive Emotions
RC3 Cynicism
RC4 Antisocial Behavior

RC6 Ideas of Persecution
RC7 Dysfunctional Negative Emotions
RC8 Aberrant Experiences
RC9 Hypomanic Activation

MMPI-2-RF Somatic/Cognitive and Internalizing Scales

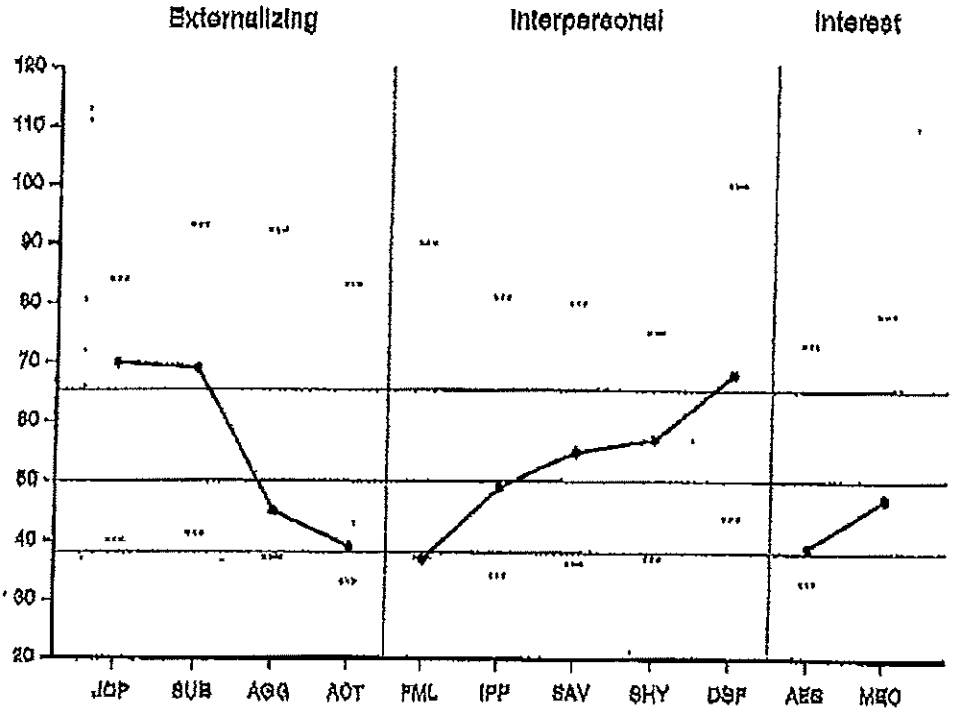


	MLS	GIC	HPC	NUC	COG	SUI	HLP	SFD	NFC	STW	AXY	ANP	BRF	MSF
Raw Score:	1	0	0	2	0	0	1	0	1	0	0	0	0	3
T Score:	46	46	42	59	40	45	52	42	48	66	44	64	48	48
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100

The highest and lowest T scores possible on each scale are indicated by a "...": MMPI-2-RF T scores are non-gendered.

MLS	Malaise	SUI	Suicidal/Death Ideation	AXY	Anxiety
GIC	Gastrointestinal Complaints	HLP	Helplessness/Hopelessness	ANP	Anger Proneness
HPC	Head Pain Complaints	SFD	Self-Doubt	BRF	Behavior-Restricting Fears
NUC	Neurological Complaints	NFC	Ineffica cy	MSF	Multiple Specific Fears
COG	Cognitive Complaints	STW	Stress/Worry		

MMPI-2-RF Externalizing, Interpersonal, and Interest Scales

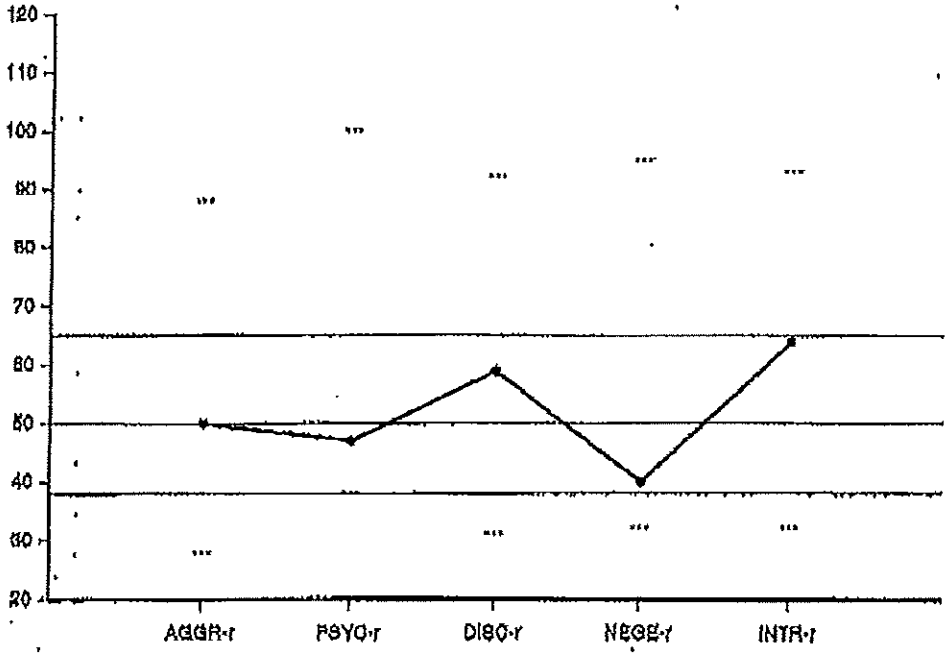


	JOP	SUB	AGG	ACT	FML	IPP	SAV	SHY	DSF	AES	MEC
Raw Score:	4	4	1	1	0	4	5	5	2	1	2
T Score:	70	69	46	39	37	49	55	57	68	39	47
Response %:	100	100	100	100	100	100	100	100	100	100	100

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.

JOP Juvenile Conduct Problems
SUB Substance Abuse
AGG Aggression
ACT Activation
FML Family Problems
IPP Interpersonal Passivity
SAV Social Avoidance
SHY Shyness
DSF Disaffiliativeness
AES Aesthetic-Literary Interests
MEC Mechanical-Physical Interests

MMPI-2-RF PSY-5 Scales



	AGGR-r	PSYC-r	DISC-r	NEGE-r	INTR-r
Raw Score:	9	1	10	2	11
T Score:	50	47	59	40	64
Response %:	100	100	100	100	100

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.

AGGR-r Aggressiveness-Revised
PSYC-r Psychoticism-Revised
DISC-r Disconstraint-Revised
NEGE-r Negative Emotionality/Neuroticism-Revised
INTR-r Introversion/Low Positive Emotionality-Revised

This interpretive report is intended for use by a professional qualified to interpret the MMPI-2-RF. The information it contains should be considered in the context of the test taker's background, the circumstances of the assessment, and other available information.

SYNOPSIS

This is a valid MMPI-2-RF protocol. Scores on the substantive scales indicate behavioral and interpersonal dysfunction. Behavioral-externalizing problems include antisocial behavior, juvenile conduct problems, and substance abuse. Interpersonal difficulties relate to a dislike of people and being around them.

PROTOCOL VALIDITY

This is a valid MMPI-2-RF protocol. There are no problems with unscorable items. The test taker responded to the items relevantly on the basis of their content, and there are no indications of over- or under-reporting.

SUBSTANTIVE SCALE INTERPRETATION

Clinical symptoms, personality characteristics, and behavioral tendencies of the test taker are described in this section and organized according to an empirically guided framework. Statements containing the word "reports" are based on the item content of MMPI-2-RF scales, whereas statements that include the word "likely" are based on empirical correlates of scale scores. Specific sources for each statement can be viewed with the annotation features of this report.

Somatic/Cognitive Dysfunction

There are no indications of somatic or cognitive dysfunction in this protocol.

Emotional Dysfunction

There are no indications of emotional-internalizing dysfunction in this protocol.

Thought Dysfunction

There are no indications of disordered thinking in this protocol.

Behavioral Dysfunction

The test taker reports a significant history of acting-out, antisocial behavior[1] and is likely to have poor impulse control[2], to have been involved with the criminal justice system[3], and to have difficulties with individuals in positions of authority[4]. He is also likely to act out when bored[5] and to have antisocial characteristics[6]. He also reports a history of problematic behavior at school[7]. He is likely to have a

history of juvenile delinquency and criminal and antisocial behavior[4] and to experience conflictual interpersonal relationships[4]. In addition, he reports significant past and current substance abuse[9], and is indeed likely to have a history of problematic use of alcohol or drugs[10], to be sensation-seeking[11], and to have had legal problems as a result of substance abuse[11].

Interpersonal Functioning Scales

The test taker reports disliking people and being around them[12], and is likely to be asocial[13] and socially introverted[13], but his asocial behavior is not associated with social anxiety[14].

Interest Scales

The test taker reports an average number of interests in activities or occupations of an aesthetic or literary nature (e.g., writing, music, the theater)[15]. He also reports an average number of interests in activities or occupations of a mechanical or physical nature (e.g., fixing and building things, the outdoors, sports)[16].

DIAGNOSTIC CONSIDERATIONS

This section provides recommendations for psychodiagnostic assessment based on the test taker's MMPI-2-RF results. It is recommended that he be evaluated for the following:

Behavioral-Externalizing Disorders

- Antisocial personality disorder, substance use disorders, and other externalizing disorders[17]

TREATMENT CONSIDERATIONS

This section provides inferential treatment-related recommendations based on the test taker's MMPI-2-RF scores.

Psychotherapy Process Issues

- Acting-out tendencies can result in treatment non-compliance and interfere with the development of a therapeutic relationship[11].
- His aversive response to close relationships may make it difficult to form a therapeutic alliance and achieve progress in treatment[9].

Possible Targets for Treatment

- Inadequate self-control[18]
- Reduction or cessation of substance abuse[10]

ITEM-LEVEL INFORMATION

Unscorable Responses

The test taker produced scorable responses to all the MMPI-2-RF items.

Critical Responses

Seven MMPI-2-RF scales--Suicidal/Death Ideation (SUI), Helplessness/Hopelessness (HLP), Anxiety (AXY), Ideas of Persecution (RC6), Aberrant Experiences (RC8), Substance Abuse (SUB), and Aggression (AGG)--have been designated by the test authors as having critical item content that may require immediate attention and follow-up. Items answered by the individual in the keyed direction (True or False) on a critical scale are listed below if his T score on that scale is 65 or higher. The percentage of the MMPI-2-RF normative sample that answered each item in the keyed direction is provided in parentheses following the item content.

Substance Abuse (SUB, T Score = 69)

49. I have enjoyed using marijuana. (True, 29.6%)
141. I have used alcohol excessively. (True, 34.2%)
237. Except by doctor's orders I never take drugs or sleeping pills. (False, 27.4%)
266. I have a drug or alcohol problem. (True, 5.0%)

ENDNOTES

This section lists for each statement in the report the MMPI-2-RF score(s) that triggered it. In addition, each statement is identified as a Test Response, if based on item content, a Correlate, if based on empirical correlates, or an Inference, if based on the report authors' judgment. (This information can also be accessed on-screen by placing the cursor on a given statement.) For correlate-based statements, research references (Ref. No.) are provided, keyed to the consecutively numbered reference list following the endnotes.

[1] Test Response: RC4=73
[2] Correlate: RC4=73, Ref. 2, 3, 6, 7, 8, 10, 13, 14, 16
[3] Correlate: RC4=73, Ref. 1, 4, 8, 11, 14
[4] Correlate: RC4=73, Ref. 14; JCP=70, Ref. 14
[5] Correlate: RC4=73, Ref. 14
[6] Correlate: RC4=73, Ref. 4, 5, 9, 10, 11, 12, 13, 14, 15
[7] Test Response: JCP=70
[8] Correlate: RC4=73, Ref. 8, 11, 14; JCP=70, Ref. 14
[9] Test Response: SUB=69
[10] Correlate: RC4=73, Ref. 1, 2, 4, 5, 8, 9, 11, 13, 14, 15, 16; SUB=69, Ref. 14
[11] Correlate: SUB=69, Ref. 14
[12] Test Response: DSF=68
[13] Correlate: DSF=68, Ref. 14
[14] Inference: SAV<65 and SHY<65
[15] Test Response: AES=39
[16] Test Response: MEC=47
[17] Correlate: RC4=73, Ref. 5, 10, 13, 14, 15; JCP=70, Ref. 14; SUB=69, Ref. 14
[18] Inference: RC4=73
[19] Inference: DSF=68
[20] Inference: SUB=69

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End of Report

ITEM RESPONSES

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